

PHYSICIAN APPLICATION TO
CORRECT A MICHIGAN DEATH RECORD

(For deaths that occurred **PRIOR** to Jan. 1, 2004)

(Fee Required)

For additional information
(517) 335-8660
Mon-Fri 8:00 am - 5:00 pm ET

MAIL APPLICATION, INCORRECT DEATH RECORD AND PROPER FEE TO:

Vital Records Changes
P.O. Box 30721
Lansing MI 48909

PHYSICIAN REQUESTING CORRECTION		PLEASE PRINT CLEARLY AND LEGIBLY											
Applicant must be the physician who certified the death. Please provide your name and complete mailing address to mail the new record to you, and a phone number to contact you if there are questions regarding this request.													
Physician's Name:													
Mailing Address:													
City, State, Zip Code:													
Daytime phone:	Area Code and Number												

DECEDENT'S INFORMATION	
NAME OF DECEDENT (First, Middle, Last)	DATE OF DEATH (Month, Day, Year)
LOCATION OF DEATH (Pronounced place of death - specify hospital, facility, or other location - city and county)	GENDER <input type="radio"/> Male <input type="radio"/> Female

INSTRUCTIONS: Please enter the correction for any items in error on the original death certificate in the appropriate spaces below.

26. PART I Enter the diseases, injuries, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, IF ANY , leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. _____ b. _____ c. _____ d. _____	_____ _____ _____ _____
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I _____	27a. WAS AN AUTOPSY PERFORMED? (Yes or No)	27b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)

28. ACTUAL PLACE OF DEATH (Home, Nursing Home, Hospital, Ambulance) (Specify)		29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Specify Yes or No)	
33a. ACC, SUICIDE, HOM, NATURAL OR PENDING INVESTIGATION (Specify)	33b. DATE OF INJURY (Month, Day, Year)	33c. TIME OF INJURY AM PM	33d. DESCRIBE HOW INJURY OCCURRED
33e. INJURY AT WORK (Specify Yes or No)	33f. PLACE OF INJURY - at home, farm, street, factory, office building, etc. (Specify)	33g. LOCATION - Street or R.F.D. No. City, Village or Twp State	

PART III

OTHER CHANGES REQUESTED

Please list below any changes requested relating to the medical facts of this death that are not addressed in Part I or II of this application:

- Item to be changed: _____
Information as it appears now: _____
Information as it should appear: _____
- Item to be changed: _____
Information as it appears now: _____
Information as it should appear: _____

I request that an amended certificate of death be filed in accordance with the facts set forth in this application.

K Physician's Signature: _____ Date: _____
Physician's License Number: _____

OFFICE USE ONLY - DO NOT WRITE IN THIS AREA

PENALTIES: Any person who willfully and knowingly makes false application to change a Michigan vital record may be fined and/or imprisoned, pursuant to MCL 333.2894(1)(b) and (c).

PAYMENT - The fee for correcting a Michigan death record is \$40.00 and includes one copy of the record with the changes made. Additional copies of the new record are available for \$12.00 each when ordered at the same time. **Payment must be made by check or money order and made payable to the "State of Michigan."**

Application Fee (Non-Refundable) Fee includes one (1) certified copy of the record	\$ 40.00	\$ 40.00
_____ Additional Certified Copies	\$ 12.00 Each	\$
TOTAL ENCLOSED:		\$